OPEN ACCESS

Reorganising our heads for the care of our health

Henry Mintzberg

Desautels School of Management, McGill University, Montreal, Quebec, Canada

Correspondence to
Dr Henry Mintzberg, Management, McGill University, Montreal, Canada; Henry.mintzberg@mcgill.ca

Received 15 September 2023
Accepted 26 January 2024

Because healthcare is a calling, we must cease trying to run it like a business. Hospitals are not factories, and 'CEOs' (Chief Excutive Officer) who look on the 'workers' of healthcare as detached 'human resources' instead of devoted human beings are a menace to our health. A striking article in *The New York Times* recently described the 'corporatisation' of American healthcare as a 'moral crisis'.[1]

This calling resides in the personal proficiency of professionals beyond the technical efficiency of systems. It requires a form of organisation that can be called the Professional Assembly, which differs markedly from another form that can be called the Programmed Machine—top-down technocratic—which is common in business. Yet this distinction is hardly recognised by those administrators of healthcare who see their role as controlling the operations with technocratic fixes, whether in the socialised healthcare of England or the market healthcare of America.

To understand why this persists, and what can be done about it, we shall have to reorganise our heads, to see healthcare for what it is and is not. Woven below are five postulates, sequenced to help us step back from the never-ending administrative crises, to appreciate a bigger picture of the care of our health. These postulates have been informed by substantial and often unfortunate experience, as discussed at length in my book *Managing the Myths of Health Care*.[2]

Postulate 1: We may talk incessantly about its failures, but healthcare, in fact, suffers from success. In the advanced economies at least, healthcare services are succeeding, outstandingly, but often expensively, and we do not want to pay for that, especially in the form of taxes, but also in elevated insurance premiums.

Physicians, scientists and others have been brilliant at finding new and expensive ways to treat our diseases specially pharmaceutical companies.[3] As a consequence, beyond the immediate costs of these treatments, we live longer, and thus incur even more costs. We want the benefits of all this but not the costs, the treatments but not the taxes. Consequently, those agencies that fund the services, publicly or privately, get squeezed.

And so they squeeze back. Hesitant to cut services, they cut costs, by imposing administrative fixes on the operations. One American physician complained of having had to squeeze appointments into 7 min time slots.[4] Unfortunately, such fixes do not work well in professional services; indeed, they often undermine them as a calling. And herein lies much of the failure.

Postulate 2: Reorganisations mostly distract rather than improve the practices of the professionals. When I first visited the National Health Service (NHS) of England in the early 1990s, it was organised into 175 Districts that reported to 14 Regions—and the 50 Areas in between had just been discarded. On a return visit in 2006, I found only 'Strategic Health Authorities,' 28 in number—in other words, no more Regions, no more Districts, just something closer to Areas—which were soon reorganised into 17, and then 10. No wonder a *BMJ* editorial once described the NHS as being in a state of constant 'redisorganisation'.[5] Tell me, what difference does all this reorganising make to a surgeon putting in a stent…other than driving him or her to distraction?

Reorganising is so common in organisations because it's so easy, in conception if not consequence. All it takes is a sheet of paper and a pencil, with a good eraser. These people go here, those people go there, at least on the chart. Such reorganising is incessant in public healthcare because changing it for real is so difficult. Yet the governments have to do something, and so the administrators change the charts. The managers get shuffled around…while that surgeon with the stent carries merrily along—once the distraction abates.

Postulate 3: Performance measurements are not suited to controlling professional services. It may be easy enough to measure the efficiency of producing automobiles on an assembly line. But how about measuring the proficiency of treating patients in a psychiatric clinic? Even in surgery: Are you in need of a difficult operation? Let me suggest that you find a surgeon with a high death rate. Not because that person is incompetent, rather because he or she takes on the difficult cases. (This example is not fanciful: I have read about surgeons who refuse to do so for fear of messing up their numbers.)

Have you ever met a number that cannot be gamed, especially by a professional? Successive Quebec governments have sought to impose the minimum number of patients each general practitioner (GP) has to take in their practice, earlier 1000, later more. Imagine the field day they could have with this number—avoiding the older patients, for example. Of course, the government could then measure their age. And next, their health?

Accordingly, beware of efficiency in fields such as healthcare, because it often reduces to economy, namely cutting measurable costs at the expense of difficult-to-measure benefits, most notably in the quality of the services.[6]

Unlike the Americans, we in Canada do not favour markets in our healthcare because we know they can be crass—for example, having to fight with insurance companies about prescribing an expensive medicine, on one hand, and being pushed to use a needless test, on the other. Yet we accept the interventions of governments that are often crude—more inclined to use axes than scalpels—and nowhere more so than with their measurements, like those 1000+GP patients. Sure, some numerical

To cite: Mintzberg H. *BMJ Leader* Published Online First: [*please include* Day Month Year]. doi:10.1136/leader-2023-000912

controls are necessary, especially to keep a lid on costs, but not mindlessly so.

Postulate 4: Coming down the administrative hierarchy, these fixes fail at the great divide in healthcare, where they meet the Professional Assembly which they seek to manage like a Programmed Machine.

In my new book, *Understanding Organizations…Finally*, I describe these two fundamental forms of organisation, among others.[7] In one, the professionals assemble to work mainly on their own, serving their clients directly for the sake of proficiency. Much of this work requires customised service on a human scale[8] more than impersonal interventions on an economic scale. This renders the Professional Assembly a highly decentralised structure.

In sharp contrast is the Programmed Machine, commonly found in the mass production of business and the clerical services of government, where the work tends to be rather unskilled. This form is highly centralised for efficiency, through the use of technocratic controls to standardise such work—measuring the time spent on micro-activities, for example.

These two forms mix like water and oil. When the administrators of healthcare try to manage a professional Assembly as if it was a Programmed Machine, they hit what can be called the great divide of healthcare, where their fixes coming down the hierarchy meet the professional services at the base. The professionals simply have to be responsive to the protocols of their profession, rather than to the charts and measures dictated in some distant office, at least if they are to honour their calling.

Hence, we need to cease imposing changes from 'above', so that professionals and administrators can meet at this divide, collaboratively, to get past the long-standing conflictive behaviours on both sides. Together they will have to solve the tangible problems that arise in their particular context, within the fiscal constraints.

Postulate 5: For the sake of the necessary collaboration, effective organisations in healthcare will have to foster communityship, beyond leadership. I coined the word communityship in 2006[9] to draw a contrast with leadership, especially of the heroic kind, also ownership, of the investor kind.

Healthy organisations function internally as communities of engaged human beings, especially when they are embedded in their natural communities. Thanks to their status as a calling, healthcare organisations have a head start in both respects. Internally, they tend to be more naturally decentralised than most other organisations, hence more predisposed to function as communities, especially when they are trusts, namely free of the control of investors. And externally, many are closely associated with their local communities—indeed, many are at the centre of it. (Consider the extent of volunteering in local hospitals.)

Working against this head start, however, is a built-in weakness of the Professional Assembly. Used to functioning rather autonomously, its professionals tend to resist collaboration, even with each other, let alone with the administrators, especially when the latter has been heavy-handed. Yet some of their own work requires collaboration with colleagues, on difficult clinical cases, for example, and in doing sophisticated research. And administrative work in general requires a great deal of collaboration, especially at the great divide, where the professionals and the administrators have to work out the problems together. Hence, the effective healthcare organisations of the future will have to prioritise communityship.

Contrast communityship with leadership, which has become somewhere of a cult today. Utter the word leadership, or leader, and what comes to mind is a single individual—the proverbial maestro on the podium, so to speak.[10] Hence, when we promote leadership, we may unwittingly be demoting everyone else, as followers, and thus encouraging the concentration of power—too often these days, the narcissistic use of it.[11]

Those in healthcare who take the 'leader' label seriously, not to mention that of being a 'CEO' (ie, pretending to be running a business), risk macroleading instead of micromanaging—and, frankly, I don't know which is worse. Micromanaging meddles where managers should stay clear, while macroleading stays clear when managers should be engaged: they deem from on high instead of getting informed throughout. To reiterate, effective healthcare requires open communication with respectful collaboration, nuanced across the great divide, by people thoroughly informed about each other's concerns.

To conclude: Certainly, we have to measure what we must, and organise the administrative apparatus of healthcare to function in support of the operations, while ensuring adequate control of the costs. Otherwise, please: Enough of the relentless reorganising, enough of the measuring like mad, enough of the charts that stack 'leaders' on 'leaders', with a 'CEO' on top, enough of the cost-cutting that undermines healthcare as a calling. All of this has caused enormous damage already. Let's reorganise our heads for a change, by stepping back to see healthcare for what it really is, and is not.

Contributors This commentary is solely written by HM.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient consent for publication Not applicable.

Provenance and peer review Not commissioned; externally peer reviewed.

ORCID iD

Henry Mintzberg http://orcid.org/0009-0008-8754-0865

REFERENCES

1 Press E. n.d. The moral crisis of America's doctors", the New York Times (15 June 2023). "… many physicians have found themselves subjected to practices more commonly associated with manual laborers in auto plans or Amazon warehouses, like having their productivity tracked on an hourly basis, and being pressured by management to work faster.
2 Mintzberg H. *The Myths of Health Care*. Oakland,CA: Berrett-Koehler Publishers, 2017: 272.
3 Mintzberg, H. (2006). Patent Nonsense: Evidence tells of an industry out of social control. CMAJ, 175(4), 374-374.
4 Press E. n.d. The moral crisis of America's doctors", the New York Times (15 June 2023).
5 Smith J, Walshe K, Hunter DJ. The "redisorganisation" of the NHS. BMJ 2001;323:1262–3.
6 Mintzberg H. "What could possibly be wrong with "efficiency"? Plenty". 2017. Available: https://mintzberg.org/blog/what-could-possibly-be-wrong-with-efficiency-plenty
7 Mintzberg H. Understanding Organizations…Finally. Berrett-Koehler. The other two fundamental forms not described here are the personal enterprise and the project pioneer. 2023.
8 Mintzberg H, Lampel J. (Fall, 1996) "Customizing Customization", Sloan Management review. Health care services are closest to "tailored customization", rather than "pure customization."
9 Mintzberg H. "Community-ship is the answer" Financial Times (23 October, 2006). See also (2009). Rebuilding companies as communities. Harvard Business Review, 87(7/8), 140-143..
10 Mintzberg H. (November-December, 1998) "Covert leadership: The art of managing professionals." Harvard Business Review.
11 Mintzberg H. Abusive bosses too; Available: https://mintzberg.org/blog/abusive-bosses